HEALTH BENEFIT PLAN RATE FILING
Submission Requirements
In Reference to Health Benefit Plan as Defined in Kentucky Revised Statute 304.17A-005 and Administrative Regulation 806 KAR 17:150E

1. An insurer shall submit a separate filing for each of the following market segments:

   a. Individual
   b. Small Group
   c. Association

   and filing types:

   a. Conversion
   b. Employer-Organized Association
   c. Guaranteed Loss Ratio (GLR)
   d. Insurance Purchasing Outlet

2. An insurer may submit separate filings for each of the following product types or in the following combinations:

   a. FFS and PPO; or
   b. HMO, POS, and PPO

3. Each filing shall include two (2) copies of the following forms:

   a. HIPMC-R32 Health Benefit Plan Rate Filing Information Form
   b. HIPMC-F1 Face Sheet and Verification Form
   c. Income and Expense Worksheet
   d. HIPMC-R34 Certification Form

4. The following shall accompany each filing:

   a. A fee of **$100** (or Domicilatory Fee-whichever is greater)
   b. Annual Report (1 copy)
   c. Self-addressed and postage-paid envelope (1)
   d. **$50** fee for Amendment to previous approved filing

5. An insurer shall submit one copy of **all** written material to the Attorney General's Office at the same time as the written material is submitted to the Department of Insurance. Written materials include:

   a. Amendments
   b. Updates
   c. Additional information
   d. Responses to inquiries from the Department of Insurance
   e. **Two copies** of all correspondence, with the Department or other state agency, concerning the filing shall be submitted by the insurer to the Department

6. The actuarial memorandum for each rate filing shall be prepared in accordance with the American Academy of Actuaries Actuarial Standard of Practice No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans and Interpretative Opinion 3, Professional Communications of Actuaries and shall include:

a. Qualifications of the signing actuary
b. A statement identifying when the company will begin using the proposed rates

7. Each filing's actuarial memorandum and information shall include a discussion of the rate development and a detailed explanation of the following:

a. The effects of each of the following mandated benefits with the percentage cost and actual dollars attributable to the rates and the number of affected policyholders for:

- Treatment of inherited metabolic disorders
- Plans offering pharmacy benefits, formula costs of inherited metabolic disorders
- Mammograms
- Mental Health Conditions in accordance with KRS 304.17A-661 (applicable to Associations & Large Group filings only

. b. The claims cost development including:

- Methodology
- Any assumption
- Trend and supporting analysis which supports the trend level selected
- Any benefit change
- Any utilization or cost-per-service change
- Any demographic change
- Any change in medical management
- Any change in provider contracts
- Any other assumption used and

c. Experience by month, including exposures or members, earned premium, paid claims, incurred claims and incurred loss ratio, for the last three (3) years for this product, or for a similar product if this filing is for a new product

d. **Each filing shall include the development and printout, as an exhibit of:

- The base premium rates, index rates, and corresponding highest premium rates for the **standard plan option** by age, gender, and tier combination using the lowest industry factor and the lowest area factor and
- Separately using the highest industry factor and the highest area factor

e. If the filing contains more than one (1) product, the information in **d above shall be provided for each product separately

f. For any filing containing proposed rates for more than (1) one class of business, the information required in **d above shall be provided separately for each class of business

g. Every factor for each case characteristic including:
- Age
- Gender
- Industry or occupation
- Geographic region

with a separate summary of the maximum and minimum factor for each case characteristic (5:1)

h. Only health benefit plan regions from the eight (8) identified in HIPMC R-33 shall be used for a geographic region factor adjustment

i.. Any healthy lifestyle discount factor, along with an explanation of the determination of that factor, and where that factor is applicable

j. The anticipated pricing loss ratio including detailed justification of the following load factors and percentages allocated with an explanation for any change from the factor used for existing rates and an explanation of how these costs are allocated among each benefit plan design and attach demonstrative documentation as an exhibit:

- Administrative expenses
- Commissions
- Federal, state and local taxes
- Investment income
- Profit and contingency
- Assessments (KY Access/GAP) pursuant to KRS 304.17B-021; and
- Any other identified factors

k. A detailed explanation, with examples, of:

- The method for determining a small group composite rate
- When a small group composite rate is recalculated and
- The group size that is eligible for a composite rate calculation

l. Each health benefit plan description and the applicable benefit factor adjustment, or any other method of calculating rates for a different benefit plan if the method is not multiplicative, for each benefit plan to which this filing applies

m. A detailed discussion of how the projected net assessments and refunds under KY Access/GAP (KRS 304.17A-460 and KRS 304.17A- 470) are included in establishing the proposed rates in the filing

n. Information regarding how fees are paid to providers as follows:

- Justification of fees paid to providers in relation to the rate requested, including any assumption used regarding provider discounts in the rate filing
- The average discount to providers during experience period and average discount for the following payments:
    - physician
    - hospital
    - laboratory
    - pharmacy

- mental health
- any other payments for the rate filing period

o. The trend rate, if used, including the time period to which the trend applies and the applicable annual trend rate and the periodicity of the factor, such as monthly or quarterly

p. Anticipated effect of the rates on the current policyholders/subscribers/ enrollees

q. Information regarding each class of business shall include:

- Identification of each class of business;
- Justification of each separate class of business; and
- A demonstration that each index rate for the class of business with the highest index rates is within ten (10) percent of the corresponding index rate from the class of business with the lowest index rates, and, effective January 1, 2001, excluding any GAP class of business

8. Prospective certification (HIPMC-34) of the following, filed as an attachment to the actuarial memorandum for an Individual, Association, and Small Group rate filing (excluding Large Group), and signed by the qualified actuary who prepared and signed the actuarial memorandum:

a. That the information is prepared in accordance with American Academy of Actuaries Actuarial Standard of Practice No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans, applicable to the following markets

b. That all the proposed rates are in compliance with KRS 304.17A-0952 and 304.17A-0954

1. Each **EMPLOYER-ORGANIZED ASSOCIATION** rate filing shall also contain the following:

   a. Name of the employer-organized association generating the rating experience

   b. Each employer-organized association rate filing shall contain documentation demonstrating that the entity is an employer-organized association pursuant to KRS 304.17A-0954(1)(c)

2. Each employer-organized association electing to provide an insurer with written permission to base the employer-organized association's rates on experience other than its own may have its experience combined for the employer-organized association's rate determination

3. Proposed rates for a combination of employer-organized associations shall be contained in one (1) filing

4. If an insurer is proposing to begin marketing a health benefit plan to an employer-organized association, a rate filing may be based on the standard plan benefits, including appropriate formulas and rate factors within the limitations outlined in KRS 304.17A-0954. The filing shall include:

   a. Factors for any plan to be offered and

   b. A detailed description of the methodology for incorporating the actual experience of an employer-organized association in determining the rates

5. If an insurer receives written permission from an employer-organized association regarding combining experience with other employer - organized associations, the insurer shall submit two (2) copies of the written permission to the commissioner at the time of the rate filing. The written permission shall include the following

   a. A statement giving the insurer permission to rate the employer-organized association on experience other than the employer-organized association’s own experience;

   b. Name, address, and telephone number of the employer-organized association giving permission to the insurer;

   c. Name, address, and telephone number of the insurer to which permission is given;

   d. Month, day, and year that permission is given to the insurer; and

   e. Number of eligible association members.

1. Each filing accompanied by a **GUARANTEED LOSS RATIO (GLR)** statement shall also meet all requirements of KRS 304.17A-095(6)

2. Each filing accompanied by a guaranteed loss ratio statement for the Individual, Small Group, or Association market shall meet the following requirements regarding guaranteed loss ratios by duration

   a. The guaranteed loss ratio for the first duration shall not be less than sixty (60) percent of the guaranteed lifetime loss ratio specified in the policy

   b. Expected loss ratios may vary by month within the first duration

   c. The loss ratio for the first month shall not be less than fifty (50) percent of the guaranteed loss ratio for the first duration

   d. The loss ratio for each month following the first month shall be greater than the loss ratio for the immediately preceding month

   e. The average of the loss ratios for all months shall be equal to the guaranteed loss ratio for the first duration

   f. The guaranteed loss ratio for a specific duration shall not be less than the guaranteed loss ratio for the previous duration

   g. The guaranteed loss ratio for the third duration shall not be less than the guaranteed lifetime loss ratio specified in the policy

   h. The average of the first six guaranteed loss ratios by duration shall not be less than the guaranteed lifetime loss ratio specified in the policy

   i. The guaranteed lifetime loss ratio shall not be less than that contained in KRS 304.17A-095(6)(a)

   j. The guaranteed loss ratios by duration are guaranteed for all policies issued under the policy form and shall be specified in the policy

3. An initial rate filing shall be a formal filing and a subsequent rate filing may be by actuarial certification